SUBCOMMITTEE NO. 3 Agenda
Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Elaine K. Alquist

Senator Alex Padilla
Senator Mark Wyland

April 28, 2008

10:30 AM

Room 112

AGENDA

(Diane Van Maren)

Item	**Department**
4120	**Emergency Medical Services Authority (Vote Only)**
4260	**Department of Health Care Services**
4265	**Department of Public Health**
4440	**Department of Mental Health**

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

A. ITEM FOR "VOTE-ONLY"—EMERGENCY MEDICAL SERVICES

1. Pharmaceutical Cache (Stand By) for Mobile Hospital (Finance Letter)

Issue. The Subcommittee is in receipt of a Finance Letter for the Emergency Medical Services Authority (EMSA) requesting an increase of $448,000 (General Fund) to fund pharmaceutical cache for the Mobile Field Hospitals. The EMSA states that this funding would ensure a fresh supply of pharmaceuticals to be on-hand and delivered within 48 hours of the deployment of a Mobile Field Hospital. Pharmaceutical caches consist of medications, treatment kits, intravenous solutions, and other medical supplies.

Subcommittee Staff Recommendation—Deny Augmentation. Due to the fiscal crisis, it is recommended to deny the requested augmentation of $448,000 (General Fund, ongoing).

An allocation of $18 million (General Fund, one-time only) was provided in 2006 for the purchase of pharmaceutical drugs, maintenance, medical supplies and related materials. In addition, $1.7 million (General Fund, ongoing) was provided for pharmaceutical drugs, storage, staff and maintenance.

Increased funding of $242,000 (General Fund) for equipment maintenance of the Mobile Field Hospitals has also been proposed in 2008-09 and was adopted by the Subcommittee (March 10, 2008).

In the event of an emergency, the Governor can authorize increased funding for medical supplies, including pharmaceuticals. Further, the state operates under a "mutual aid" agreement where by local governments also play a significant role in providing assistance, along with the federal government.

Due to the short shelf life of most pharmaceuticals (about 2/3rds have a 12-month shelf life with the remaining 1/3 having about an 18-month shelf like) the EMSA would need on-going support even if no emergency requiring pharmaceuticals occurred. Therefore, in order to more prudently utilize limited General Fund resources, it is recommended to deny this augmentation request.

B. ITEMS FOR "VOTE-ONLY"—DEPARTMENT OF PUBLIC HEALTH

1. Enterprise-Wide Online Licensing Project (Finance Letter)

Issue. The Department of Public Health (DPH) is proposing funds of $439,000 (various special funds) to begin implementation of an "Enterprise-Wide Online Licensing" project.

This information technology project is to replace several small systems and manual processes for license application/approval, inspection, proficiency testing, renewal, inquiry/lookup, maintenance of historical information, complaint investigation, billing and enforcement. Savings of over $900,000 are expected from gained efficiencies which will be applied to ongoing costs of the new system.

The DPH states that this project will benefit regulated entities, the health care community, selected licensing programs, and the general public. The immediate clientele of the licensing activities of the participating programs are the entities that are subject to licensing, enforcement, and billing as follows:

- Food and Drug Program. Medical device manufacturers and retailers; Drug manufacturers; Bottled water facilities; Haulers, distributors and vendors; Food manufacturers, Food and drug exporters.
- Radiation Safety Program. Radiation machines; Radiation machine operators; Radiologic technology schools; Radioactive materials.
- Drinking Water Operator Certification Program. Water treatment and water distribution operators.
- Safe Drinking Water Systems. Small water systems.
- Medical Waste Management Program. Small quantity generators; large quantity generators; storage facilities; Haulers.

This project is to be funded with nine special funds which are all fee supported. All of these special funds have sufficient funds for this purpose. There is no impact to the General Fund.

Subcommittee Staff Comment and Recommendation—Approve Request. The project makes good business sense. No issues have been raised.

2. Fresno County Small Water Systems (Finance Letter)

Issue. The DPH is requesting an increase of $430,000 (Safe Drinking Water) to fund 4 positions, all technical water classifications, to continue oversight and implementation of the small water system program in Fresno County.

The DPH notes that three of the four positions will be supported using *reserves* contained within the Safe Drinking Water Account, with the other position being funded with existing fees. Presently the fees paid by small water systems, such as these in Fresno County, pay *flat fees*. Small water systems regulated by the state with less than 1,000 service connections can only be billed at an annual flat fee that ranges from $259 to $728, depending on the number of service connections. As a result, the revenue generated by the small water system fees is insufficient to operate a minimally acceptable regulatory program.

Existing law allows counties to return small water system programs to the DPH. Due to budget shortfalls, Fresno County has recently decided to return its small water program back to the state. There are 318 small water systems in Fresno County with over 4,000 service connections which provide water to residents, visitors, and businesses. About 75,000 people are served by these service connections. Therefore, the DPH contends that positions are needed to ensure water quality and safety in Fresno County.

The DPH also expresses concern in that without funding specifically targeted to support county small drinking water systems, it is increasingly likely that other counties will return their programs to the state (i.e., DPH). The DPH notes they are currently assessing and evaluating this risk in order to develop potential options for long-term solutions.

Background—DPH and Small Water Systems. The DPH has responsibility for the regulation and permitting of public water systems. Specifically, they provide ongoing surveillance and inspections of public water systems, issue operational permits to the water systems, ensure water quality monitoring, and take enforcement actions when violations occur.

The program oversees the activities of about 8,000 public water systems that serve drinking water to more than 98 percent of the state's population. About 7,000 of these systems are small water systems which have less than 1,000 service connections each and pay flat fees.

Subcommittee Staff Comment and Recommendation—Approve with Limited-Term Positions and Trailer Bill Language. Due to the public health risk, Subcommittee staff concurs with the need for the DPH positions. *However* it is recommended to have three of the positions be two-year limited-term due to the use of reserve funds. In addition, since there are concerns regarding the viability of resources to finance small water system oversight, Subcommittee staff is recommending for the following trailer bill language to be adopted:

" In an effort to more comprehensively clarify issues regarding the state's responsibilities and oversight of small water systems, including the payment structure, the Department of Public Health will provide the fiscal and policy committees of the Legislature with a synopsis of key issues regarding the program and options for addressing the sustainability of the program to meet safe drinking water quality standards."

3. Technical Adjustment to Federal Funds (Finance Letter)

Issue. The Subcommittee is in receipt of a Finance Letter for the Department of Public Health requesting a technical adjustment to decrease by $5.8 million (Federal Trust Funds) in the support item (Item 4265-001-0890) to remove excess federal expenditure authority within several public and environmental health programs, and to adjust for an increase of $315,000 (Federal Trust Funds) in additional authority for the Women, Infants, and Children (WIC) Program.

Subcommittee Staff Comment and Recommendation—Approve Finance Letter. It is recommended to approve this Finance Letter to provide for technical federal funding adjustments. No issues have been raised.

4. Request to Develop an Office of Suicide Prevention at the DPH

Issue. The Subcommittee is in receipt of a Finance Letter for the Department of Public Health (DPH) requesting an increase of $350,000 (Mental Health Services Act Funds) and two positions to establish an Office of Suicide Prevention within the DPH.

The DPH states that it intends to expand collaboration, data collection, epidemiology and surveillance in support of the Office of Suicide Prevention within the Department of Mental Health.

Subcommittee Staff Comment and Recommendation—Deny Augmentation. It is recommended to deny this augmentation for several reasons. *First*, the DPH presently has an "Epidemiology and Prevention for Injury Control Branch which serves as a focal point for the DPH's injury prevention and surveillance efforts. This Branch receives General Fund support (4 positions), various federal grants, special funds and non-profit foundation support. As part of its portfolio, it does provide some information regarding suicide from an epidemiology/surveillance perspective and as part of its prevention program policy.

Second, the lead here is the Department of Mental Health which has already established an Office of Suicide Prevention using Mental Health Services Act Funds (i.e., Proposition 63). The DMH Office of Suicide Prevention will have positions to conduct various functions, including the collection, analysis and dissemination of suicide statistics. (See DMH discussion issues below in this Agenda).

The state should have one office accountable for this area, not multiple entities. Further the DMH, with assistance from the Oversight and Accountability Commission, could contract when needed to obtain data and analysis regarding suicide from numerous entities. The existing Mental Health Planning Council also conducts an analysis of mental health issues, including a needs assessment and could be included in any other special/focused efforts. Expertise from various foundations, the California Institute for Mental Health, the CA State University System and University of CA system could also be used where applicable.

Using the Department of Mental Health for these efforts will enable mental health advocates, the Oversight and Accountability Commission and the Mental Health Planning Council to be more directly involved with data collection and analysis.

Finally, any unspent state support funds within the Mental Health Services Fund can be redirected to local assistance. In fact this was done last year when $64 million (Mental Health Services Act Funds) in unspent funds state administration funds were transferred to local government for their expenditure for mental health services.

C. ITEMS FOR "VOTE-ONLY"-- HEALTH CARE SERVICES

1. CA Discount Prescription Drug Program—Delete Funding and Defer Implementation

Issue. Due to the fiscal crisis, the Senate has prioritized core, direct services programs as being key programs to fund. As such, new programs and pilot programs are being eliminated from the budget.

The Budget Bill of 2007 appropriated a total of $8.8 million to implement AB 2911 (Nunez), Statutes of 2006. However, it was vetoed by the Governor. For 2008-09, the DHCS proposes funding of $5.870 million (General Fund) to proceed with implementation.

Under this new program, the DHCS would conduct drug rebate negotiations, perform drug rebate collection and dispute resolution, and develop program policy, while a contractor would operate and manage the enrollment and claims processing functions.

Overall Background—AB 2911 (Nunez), Statutes of 2006. This legislation created the CA Drug Discount Prescription Drug Program to address concerns regarding the lack of access to affordable prescription drugs by lower-income Californians. This program is a drug discount program, not a benefit. The general structure of the program is for the state to negotiate with drug manufacturers and pharmacies for rebates and discounts to reduce prescription drug prices for uninsured and underinsured lower-income individuals.

Participation in the program is eligible uninsured California residents with incomes below 300 percent of the federal poverty, individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family's income, share-of-cost Medi-Cal enrollees, and Medicare Part D enrollees that do not have Medicare coverage for a particular drug.

Enrollment in the program is to be simple and most likely will occur through local pharmacies. The only fees charged to individuals will be a $10 enrollment fee for processing the initial program application and an annual $10 re-enrollment fee. The legislation allows pharmacies and providers to keep the $10 enrollment fee as payment for their assistance to enroll clients in the program.

Subcommittee Staff Recommendation—Defer Implementation. Though implementation of this new program has merit, due to the fiscal crisis it is recommended to delay implementation of this program for 2008-09 and to delete the entire 2008-09 funding amount. The state is not in a position to commence with a new program when existing core programs, such as Medi-Cal and Healthy Families are being proposed for reduction. By deferring this program the state will save $5.870 million General Fund. This includes eliminating all applicable funding to the Fiscal Intermediary as well.

This recommendation is proposed without prejudice to funding in the future contingent upon appropriation in the annual Budget Act or other legislation. No statutory changes are proposed.

2. Extend Positions: Health Insurance Portability and Accountability Act

Issue. The DHCS is requesting an increase of $1.550 million ($218,000 General Fund) to extend 11.5 limited-term positions for three years (June 30, 2011) and to make one temporary position permanent.

The DHCS states that all of the positions are filled and are conducting mission critical aspects of meeting requirements as contained in the federal Health Insurance Portability and Accountability Act (HIPAA).

One of the most significant challenges to becoming HIPAA compliant has been transitioning the many local operational codes in the Medi-Cal Program, primarily for medical services, equipment and supplies, to national standards. Prior to HIPAA, the DHCS had nearly 8,500 local codes and modifiers that were not HIPAA-compliant.

The process to define policy, adjust rates, adequately communicate the changes to the provider community, and modify the payment systems t incorporate these changes is complex, resource intensive, and lengthy.

Subcommittee Staff Recommendation--Approve. Subcommittee staff concurs with the request and has raised no issues. The LAO also concurs with the request.

3. State Support—Reduce Primary Care and Rural Health Staff

Issue. As part of his across-the-board 10 percent reduction, the Governor is proposing to reduce the DHCS, Primary Care and Rural Health Branch by $108,000 (General Fund). The DHCS proposes to reduce by 1.5 staff positions to meet this reduction amount. Specifically, an Office Assistant and a part-time Research Program Specialist will be eliminated. The DHCS states that they will shift workload and make reporting adjustments to accommodate the reduction.

Subcommittee Staff Recommendation—Adopt Governor's Reduction. It is recommended to adopt the Governor's reduction. No issues have been raised.

<u>4. CA Working Disabled Program—Proposal to Extend Sunset</u>

<u>Issue.</u> The DHCS proposes to extend this program, which is scheduled to sunset as of September 1, 2008, for only one more year (to September 1, 2009). No funding issues have been raised.

<u>Background on Program.</u> The CA Working Disabled Program provides Medi-Cal eligibility to disabled individuals who are employed with countable income at or below 250 percent of the federal poverty level. It permits these individuals to buy into the Medi-Cal Program through the payment of low monthly premiums.

Prior to the implementation of this program, many disabled individuals wishing to return to work faced losing their medical coverage because of increased income. With enactment of AB 155, Statutes of 1999 and the subsequent implementation of the 250 percent (net countable income below 250 percent) CA Working Disabled Program, individuals were offered to buy into Medi-Cal.

The DHCS notes that the program is cost-beneficial to the state because it allows disabled individuals to remain in community or home-based settings rather than costly institutionalization in nursing facilities or other long-term care facilities. There are about 3,500 individuals currently participating in the program.

<u>Subcommittee Staff Comment and Recommendation—Eliminate Sunset Provision.</u> This program enables working disabled to buy into the Medi-Cal Program in order to receive health care services to maintain their employment. It keeps people working and is cost-beneficial to the state.

There have been numerous sunset extensions on this program which was enacted in 1999. Therefore, it is recommended to delete the sunset provision altogether versus extending it for only one more year. This deletion would permanently establish the program.

5. Medi-Cal for Kinship Guardianship Assistance—Trailer Bill Language

Issue and Background. The DHCS is proposing trailer bill language to conform Medi-Cal statute with KinGAP statute by establishing a state-only Medi-Cal Program for KinGAP children. This statutory change will enable about 200 children to continue to receive needed health care services through Medi-Cal.

The foster care program is administered by the Department of Social Services (DSS). Since foster care workers are authorized to conduct Medi-Cal eligibility determinations as a part of the foster care eligibility determination, foster care children automatically receive no-cost Medi-Cal benefits without a separate Medi-Cal eligibility determination.

When children leave the foster care system for KinGAP due to placement with relatives that have obtained permanent legal guardianship, these KinGAP children currently also automatically receive no-cost, full-scope Medi-Cal benefits. *However,* in order to comply with federal Medicaid law and to quality for federal financial participation, the state must conduct full Medi-Cal eligibility determinations for these KinGAP children.

Since some of the KinGAP children may not meet federal Medicaid requirements, primarily due to their guardian's assets, they will lose their full-scope Medi-Cal benefits and/or be placed in the share-of-cost Medi-Cal program.

The DHCS estimates that in the absence of this proposed legislation approximately 200 children would be determined ineligible for no-cost Medi-Cal. It must be noted that these children are currently receiving no-cost, full-scope Medi-Cal benefits. In some cases, relatives may choose not to obtain legal guardianship of these children in order to continue the child's no-cost Medi-Cal under the foster care program.

Subcommittee Staff Comment and Recommendation—Approve DHCS Language. Legislation is needed so vulnerable KinGAP children can continue to receive no-cost full-scope Medi-Cal health care services through a state-only, no-cost full-scope Medi-Cal program once they transition to a more permanent home environment with their relatives. It is good policy for the following reasons:

- In the KinGAP statutes, the Legislature clearly indicated its intent that KinGAP provide relative caregivers with the financial support they need to properly care for the child and thereby eliminate a significant barrier to creating a guardianship. Continuing to provide no-cost Medi-Cal to children leaving dependency and entering KinGAP conforms to this intent.
- Conforming the Medi-Cal statutes with the intent behind the KinGAP statutes will ensure that KinGAP children who do not meet federal Medi-Cal eligibility requirements would be able to continue ongoing medical treatments with current providers and have a medical home.
- It would encourage relatives to obtain legal guardianship of foster care children if they do not have to worry about medical costs; this would provide the children with a more stable, permanent home environment which may reduce medical costs for these children.

D. ITEMS FOR "VOTE-ONLY"—DEPARTMENT OF MENTAL HEALTH

1. Subcommittee Trailer Bill Language for State Hospitals

Prior Subcommittee Hearing—March 14th. In the March 14th hearing, the Subcommittee adopted placeholder trailer bill language to require the Department of Mental Health (DMH) to provide the Legislature with a comprehensive estimate as of January 10th (release of the Governor's budget) and at the time of the May Revision.

This proposed trailer bill language was in response to the Department of Finance's Office of State Audits and Evaluations (OSAE) report regarding the need for internal controls and fiscal accountability at the DMH, including the State Hospitals.

Subcommittee Staff Recommendation—Adopt Trailer Bill Language. After discussion with the Administration, LAO and Senate Republican Fiscal staff, the following language has been agreed to and is for adoption by the Subcommittee:

Add Section 4100.2 to Welfare and Institutions Code:

> "The Department of Mental Health shall provide the fiscal committees of the Legislature with a fiscal estimate package for the current-year and budget-year for the State Hospitals by January 10 and at the time of the Governor's May Revision commencing as of January 10, 2009 and ongoing thereafter.
>
> At a minimum, this estimate package shall address patient caseload by commitment category, Non-Level-Of-Care and Level-Of-Care staffing requirements, and operating expenses and equipment. Each submitted estimate shall articulate the assumptions and methodologies used for calculating the patient caseload factors, all staffing costs, and operating expenses and equipment. Where applicable, individual policy changes shall contain a narrative and basis for its proposed and estimated costs. Fiscal bridge charts shall be included to provide the basis for the year-to-year changes. The department may provide any additional information as deemed appropriate to provide a comprehensive fiscal perspective to the Legislature for their analysis and deliberations for purposes of appropriation."

(THIS COMPLETES THE "VOTE ONLY" AGENDA.)

ISSUES FOR DISCUSSION –HEALTH CARE SERVICES

1. Governor's Proposed Reductions to Clinic Programs

Issue. The Governor is proposing a *total reduction of $3.5 million* (General Fund) across several clinic programs administered by the Department of Health Care Services (DHCS). The Governor's proposed reduction reflects a 10 percent General Fund reduction.

In addition, the Governor is proposing trailer bill language to state that all of these programs are contingent upon appropriation in the annual Budget Act.

Generally, these clinic programs provide assistance to almost 400 clinics. Some clinics are more reliant on these state-supported funds than others, contingent on the community population whom they serve. All clinics that receive funding provide for some portion of uncompensated care in their communities.

The proposed reductions are as follows:

DHCS Clinic Program Name	Governor's Proposed Reduction	Proposed 2008-09 General Fund (with reduction)	Proposed 2008-09 Total Funds (GF, Prop 99, federal)
1. Seasonal Agricultural Migratory Worker Clinics	-$687,000	$6,184,000	$6,184,000
2. Rural Health Services Development Clinics	-$820,000	$7,383,000	$7,383,000
3. American Indian Health Clinics	-$650,000	$5,817,000	$6,241,000
4. Expanded Access to Primary Care Clinics	-$1,350,000	$12,150,000	$25,666,000
5. Grants-In-Aid	-$44,000	$397,000	$601,000
TOTAL (Rounded)	**-$3.5 million**	**$31,931,000**	**$46,075,000**

According to the DHCS, the reduction would have the following affect on clinic visits:

- 21,750 less clinic visits in the Seasonal Agricultural Migratory Worker Clinics.
- 40,590 less clinic visits in the Rural Health Services Development Clinics.
- 37,100 less clinic visits for medical services, 19,500 less dental visits, and 16,900 less public nurse visits in the American Indian Health Clinics.
- 18,800 less clinic visits in the Expanded Access to Primary Care Clinics.
- 1,700 less clinic visits in the Grants-In-Aid Program.

Background—Seasonal Agricultural Migratory Workers Clinics. Under this program, a total of 79 clinics receive funds to provide comprehensive primary care to uninsured individuals who are seasonal, agricultural, and migrant workers. According to the DHCS, these clinics provided 217,665 medical, dental and health education/nutritionist visits.

Background—Rural Health Services Development Clinics. Under this program, a total of 122 clinics receive funds to provide comprehensive primary medical and dental care to rural populations. According to the DHCS, these clinics provided 405,924 medical, dental and health education visits.

Background—American Indian Health Clinics. Under this program, a total of 75 clinics receive funds to provide comprehensive primary medical and dental care, and public health nurse visits to American Indians. According to the DHCS, these clinics provided 370,912 medical visits, 194,487 dental visits and 169,302 public health nursing visits.

Background—Expanded Access to Primary Care Clinics. Under this program, primary care clinics are reimbursed for uncompensated care provided to uninsured persons with incomes at or below 200 percent of the federal poverty level. Uncompensated care visits are reimbursed at a rate of $71.50. According to the DHCS, 423,160 uncompensated primary care visits were provided at 484 clinics.

Subcommittee Staff Comment and Recommendation—Hold Open. All of these clinic programs are well established and have been operating efficiently and effectively for many, many years. These programs provide assistance to clinics in rural areas and urban areas, and often serve special populations in need of primary care and dental services.

As noted, these program provide core health, dental and public nursing services to many of California's uninsured populations who are in working families not receiving health care coverage from employers, or not eligible for Medi-Cal or Healthy Families.

It is recommended to leave these reductions open pending receipt of the Governor's May Revision and the potential to identify other funding options.

Further, no statutory changes are necessary since all of these programs are contingent upon appropriation in the annual Budget Act and always have been.

Questions. The Subcommittee has requested the DHCS to respond to the following question.

1. **DHCS**, Please provide a *brief* description of each program and how the Governor's reduction would affect said program.

2. Proposed Reduction to Child Health & Disability Prevention Program (CHDP)

Issue. The Governor is proposing a reduction of $1.1 million (General Fund), or a 10 percent reduction, to the funds provided to Local Health Jurisdictions for county case management.

The DHCS states that Medi-Cal provides $37.5 million ($13.2 million General Fund) in funding for support of staff in local Child Health & Disability Prevention Programs (CHDP) which serve Medi-Cal eligible children who receive CHDP screening and immunization services.

County/city local health jurisdictions manage CHDP at the local level working directly with private and public providers of services. Specifically, Local Health Jurisdictions are required to perform care coordination, including approval, enrollment and oversight of providers, and outreach and education.

Background—What is the Child Health & Disability Prevention Program (CHDP)?
The CHDP provides pediatric prevention health care services to (1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and (2) children and adolescents who are eligible for Medi-Cal services up to age 21.

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent.

This program serves as a principle provider of vaccinations and facilities enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Subcommittee Staff Comment and Recommendation--Open. CHDP serves as a key program for providing health assessments and immunizations for young children. It was established in 1975 and serves to meet the state's federal requirement of providing health assessments under the federal Medicaid Early and Periodic Screening Diagnosis and Treatment benefit of the Medi-Cal Program.

This reduction could impact children's access to health assessments and immunizations which are necessary for school entry.

It is recommended to leave this issue open until the May Revision.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Since Local Health Jurisdictions are administering a state-program—CHDP--how is the Administration directing the Local Health Jurisdictions to take this reduction?

3A. CA Children's Services Program (CCS): ISSUE "A" Governor's Reductions

Issues. The Governor is proposing various reductions to the CA Children's Services (CCS) Program.

First, the rates paid to all outpatient providers under the CCS Program, including specialty care physician's services, were also reduced through the Medi-Cal 10 percent rate reduction proposed by the Governor and adopted in Special Session by the Legislature. This will take affect as of July 1, 2008. This results in a total reduction of $103.7 million ($46.5 million General Fund), including County Realignment Funds which do not flow through the state's budget but are used to support the CCS Program (i.e., it is a "Realigned" program).

Second, a reduction of $9 million ($3.6 million General Funds) to case management functions provided by County CCS Programs is proposed by the Governor. This would reduce the amount provided to counties for administrative funding in support of case management activities for CCS children enrolled in the Medi-Cal Program. This funding is allocated to individual counties in conjunction with CCS-Only state funding and federal funds provided under the Healthy Families Program (CCS-HFP children).

This case management support funding is used to maintain 1,700 county employees (statewide) who provide assistance at the local level for CCS enrolled children. The DHCS allocates this case management support funding based on state standards and caseload projections.

The DHCS states that this reduction to County CCS Programs will likely affect processing times for eligibility determinations, determining medical necessary services, and authorizing services.

Due to the medical necessity aspect of the CCS Program, counties must conduct a financial eligibility process for the children, as well as make a medical eligibility determination. This *initial* processing of new cases requires a review of financial documentation, reviews of medical charts, identification of service providers and assistance in appointment making.

County staff is also responsible for processing medical service treatment authorizations. As such service delays may result in increased use of emergency rooms for unmet medical needs.

Third, a reduction of $2.5 million ($1.270 million General Fund) within the DHCS—Children's Medical Services Branch—is also proposed. Under this reduction, the state's Children's Medical Services Branch would reduce 23 positions out of 137.5 positions, or 17 percent of the total state positions. Further, certain contracts would also be reduced.

This reduction would affect the CCS Program (mainly), as well as the Child Health and Disability Program (CHDP) and Newborn Hearing Screening Program. Specifically, potential clients of the CCS Program may experience delays in eligibility determination and there would be additional delays in approval of services delivered to clients.

In addition, less technical assistance would be provided to the counties and there would be no health education support of these programs (CCS, CHDP, Newborn Hearing Screening Program and the Newborn Hearing Screening Program).

This reduction would include closure of the San Francisco Office. This office would be consolidated with the Sacramento and Los Angeles offices.

<u>Background—What is the CCS Program.</u> The CA Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including birth defects, chronic illness, genetic disease and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

The CCS is the oldest managed health care program in the state and only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service).

CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program); **(2)** CCS and Medi-Cal eligible; and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

<u>Subcommittee Staff Comment and Recommendation—Hold Open.</u> The CCS Program is a core program that provides medical treatment to children with involved medical needs. More information is needed to better understand how the DHCS would implement the Governor's proposed reductions and what the potential consequences would be to children seeking medical treatment under the program.

<u>Questions.</u> The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of how the CCS Program operates and *specifically*, how the proposed reductions would be implemented.

2. DHCS, What are the likely consequences with respect to accessing medical treatment for children seeking care under the CCS Program?

3. DHCS, Are there any other options in which reductions or efficiencies could be made in lieu of these proposals to reduce the counties and state staff?

B. CA Children's Services Program (CCS): ISSUE "B"—Ventilator Availability

Issue. In 2007 the Legislature adopted Budget Bill Language to compel the DHCS to convene constituency group meetings, including specialty physicians, Children's Hospitals, durable medical equipment providers, and other health care experts, regarding numerous issues within the CA Children's Services Program (CCS). One of the key concerns of the Legislature in adopting this language was to address issues for transitioning medically involved children enrolled in the CCS Program from hospital to home to progress their recovery and wellness.

Though this language was vetoed by the Governor, the DHCS did convene this stakeholder group and has met on several occasions. Through these discussions a number of procedural reforms to promote more timely discharge of children from the hospital to the home were developed.

However, an impediment regarding access to medical equipment and supplies for these children making this transition continues to be a barrier. This is particularly true for ventilator dependent children. There is, and continues to be, a lack of providers to supply the equipment and services often dictated by low reimbursement for these complex services. Specifically, the following should be noted:

- The complexity of the equipment has evolved with rental rate, including supplies and accessories that can cost the providers $3.500 for initial patient set-up on two ventilators; one is a mandatory life support back-up ventilator. These accessories include items like humidifiers, battery charger and breathing circuits. However, the Medi-Cal/CCS rate for the rental of ventilators has not been adjusted for over a decade.

- A Home Health Provider must both train and monitor patient and caregivers on the use of the ventilator. Typically the average patient requires 50 hours of transition care by a Respiratory Care Practitioner over the initial 6 months after hospital discharge.

  Respiratory Care Practitioners can bill for these services under the Medi-Cal Program, but a Home Health Provider *cannot* bill for these services.

- The Home Health Provider of the ventilator must certain maintenance, including an annual biomedical maintenance by the manufacturer of the ventilator which is not reimbursed by the DHCS. The cost for just this annual maintenance is $800 to $1,000 per ventilator.

The lack of ability for timely discharge of these patients is costing Medi-Cal/CCS. The cost of an inpatient day ranges from $1,000 up to $2,500 for these patients whereas the cost of this rental equipment is about $3,000 per month.

More clarity as to what options are available for the Medi-Cal and CCS programs to address this issue is needed. Based on the most recent information obtained, there are about 760 ventilator dependent children enrolled in the CCS Program.

Subcommittee Staff Comment and Recommendation—Open. It is recommended to leave this issue open pending receipt of additional information.

1. DHCS, Please comment regarding this continued concern. What options may be available to better address the needs of ventilator dependent children enrolled in the CCS Program?

4. Proposed Self-Certification Pilot Project per SB 437 (Escutia), Statutes of 2006

Issue. The Administration proposes a total increase of $30.9 million ($14.4 million General Fund) within the Medi-Cal Program and Healthy Families Program to conduct a two-county Pilot Program as contained in Senate Bill 437 (Escutia), Statutes of 2006. As shown in the table below, most of the proposed expenditures are in the Medi-Cal Program.

Area of Expenditure	Medi-Cal Program (Total Funds)	Healthy Families Program (Total Funds)	Total Funds	Total General Fund
Pilot Caseload	$22.8 million	$5 million	$27.8 million	$13.2 million
County Administration	$1.7 million		$1.7 million	$870,000
Administrative Vendor		$600,000	$600,000	$210,000
Pilot Evaluation	$800,000		$800,000	$400,000
TOTALS	**$25.3 million**	**$5.6 million**	**$30.9 million**	**$14.7 million**

Under this pilot, two counties—Santa Clara and Orange—have been selected to conduct "self-certification" pilot projects for both the Medi-Cal and Healthy Families Program. Under this approach, as contained in statute, applicants and enrollees in certain categories of eligibility would self-certify income and assets for purposes of enrolling in these two programs.

The purpose of these pilots is to obtain data regarding the potential for streamlining program enrollment functions and to focus limited funds towards health care services and not administration and eligibility processing.

For the Medi-Cal pilot, it is assumed that 10 percent of the projected eligibility categories enroll in the pilots, or a total of 203,800 people total (more people between these two counties). With respect to the Healthy Families Program, it is assumed that a total of 11,674 children would be enrolled in the two pilots.

The two pilot projects are the first phase of the program. After an evaluation of the pilots, a statewide rollout can be conducted. Therefore, the DHCS also included funding for an evaluation component.

Background—Description of Senate Bill 437 (Escutia), Statutes of 2006. Among other things. this legislation includes strategies to promote and maximize enrollment in the Medi-Cal Program and the Healthy Families Program (HFP), improve the retention of children already enrolled, and strengthen county-based efforts to enroll eligible children in existing public programs. These strategies include the following:

- *Self Certification for the Medi-Cal Program.* The Department of Health Care Services is required to implement a process that allows applicants and enrollees of certain categories of eligibility to self-certify income and assets. This process is to be implemented in two phases. The first phase is a two-year Pilot project to be operated in two counties. Orange County has been selected to be a pilot and so has Santa Clara County. After an evaluation of the Pilot, a statewide rollout can be conducted.

- *Self Certification for the Healthy Families Program.* The Managed Risk Medical Insurance Board is required to implement processes by which applicants at the time of annual eligibility review may self-certify income rather than provide income documentation. The MRMIB will establish rules concerning which applicants will be permitted to certify income and the circumstances in which supplemental information may be required by January 2009.

Legislative Analyst's Office Recommendation. The LAO recommends deleting the pilot projects due to the fiscal crisis.

Subcommittee Staff Comment and Recommendation—Hold Open. These pilot projects offer an opportunity to finally field test more innovative approaches to conducting eligibility processing which have been discussed in various reports and analyses for years.

Due to the fiscal crisis, there may be some options available for modifying the pilot projects, such as having one county implement and deferring the evaluation component for another year, or encouraging foundation funding for the evaluation.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary as to how the pilots would operate and when they could commence.

<u>5. Medi-Cal Program Adult Day Health Care (ADHCs)--Multiple Issues</u>

<u>Issue.</u> There are two issues pertaining to the Adult Day Health Care Program.

First, is the DHCS request for an increase of $2.4 million ($1 million General Fund) for 20 new state positions. This request is in addition to the 33 new positions provided to the DHCS in 2007 to continue to implement "reforms" as contained in SB 1775 (Chesbro), Statutes of 2006.

The DHCS contends that 20 additional positions are needed to continue implementation of SB 1775, as well as to provide follow-up to the annual Medi-Cal Payment Error Study. Of the total positions, Specifically, the DHS would assign these 20 positions as follows:

- *<u>Medi-Cal Benefits, Waivers Analysis and Rates Division (Total of 1 Position).</u>* This Research Analyst II would carry out the workload generated by the new prospective rate reimbursement methodology specified in SB 1775.

- *<u>Audits &Investigations, Medical Review Branch (Total of 7 Positions).</u>* All of these positions pertain to conducting more anti-fraud activities related to the Medi-Cal Payment Error Study. This includes six Nurse Evaluator II positions and one Health Program Auditor III position. It should be noted that the DHCS redirected other staff in previous years to conduct anti-fraud activities related to the ADHCs.

- *<u>Audits & Investigations, Financial Audits Branch (Total of 8 Positions).</u>* All of these positions pertain to further implementation of SB 1775, including doing about 350 audits per year for the first three years under the ADHC reforms. This includes five Health Program Auditor III, and three Health Program Auditor IVs.

- *<u>Office of Legal Services (Total of 4 Positions).</u>* Two of the four positions would be used to assist with appeals related to the Medical Review audits (as noted above), and the remaining two would be associated with the Finance Audits (as noted above). These positions include two Staff Counsels and two Health Program Auditor positions.

- *<u>Office of Legal Services, Administrative Hearings and Appeals (Total of 2 Positions).</u>* This includes two Staff Counsel positions. These positions would be used for administrative hearings and appeals associated with the audits.

Second, the DHCS assumes savings of $27.5 million ($13.7 million General Fund) in 2008-09 by beginning implementation of the tightening of medical necessity criteria starting as of February 1, 2008. Under this action, the DHCS assumes that 30 percent of new users of ADHC services and 15 percent of old users of ADHC services will not meet the more defined medical criteria for receiving Adult Day Health Care Services.

Background—Medi-Cal Payment Error Study. The DHCS just released its 2006 "error rate" study which is an annual analysis within the Medi-Cal Program to detect, identify and prevent fraud and abuse. This is the third such study that has been completed.

The study is primarily used by the DHCS to identify where the Medi-Cal Program is at greatest risk for payment errors. The results of the study assist in the development of new fraud control strategies and determine how best to deploy Medi-Cal anti fraud resources.

Among other things, the study found that the Adult Day Health Care (ADHC) Program errors accounted for 10 percent of the overall percentage of payment error which represents a *decrease* from what was identified in 2005. ADHC errors were comprised of insufficient documentation of services and medical necessity (i.e., it is not medically necessary for the beneficiary to have received ADHC services).

The DHCS has conducted "unannounced" site visits to many ADHC providers over the past two years. Payment errors found during these unannounced site visits resulted in the imposition of sanctions. The number of ADHC providers, as well as the number of beneficiaries attending ADHCs from November 2005 to December 2006, declined significantly. It is likely that these declines are a direct result of the anti-fraud efforts undertaken by the DHCS.

Background—Key Provisions of SB 1775 (Chesbro), Statutes of 2006. This legislation was crafted in response to federal CMS concerns with California's ADHC Program.

Specifically, the federal CMS notified the DHS that certain specified changes needed to occur in the program in order for California to continue to receive federal matching funds. The state will be submitting a "State Plan Amendment" (SPA) to the federal CMS in 2009 that details the authorized reforms once implementation issues have been worked through.

SB 1755 authorizes the DHS to make major reforms to the ADHC Program over the next three years. As authorized by SB 1775, Statutes of 2006, the following significant reforms are to be instituted:

- Establish a set of definitions relating to ADHC services;
- Revise the standards for participant eligibility and medical necessity criteria in receiving ADHC services;
- Set forth new standards for the participant's personal health care provider and the ADHC center staff physician;
- Require the ADHCs to provide a set of core services to every participant every day of attendance; and
- Restructure the rate methodology to a prospective cost-based process requiring audited cost reporting.

The DHCS states that with the gradual implementation of SB 1755 reforms, it is estimated that beginning in 2011-2012 a savings of $121.8 million ($60.9 million General Fund) may be achieved. Savings leading up to 2011-2012 are expected to be limited. Savings are expected to stem from a combination of the following factors:

- Post-payment reviews with subsequent audit recoveries;
- Tightening of medical necessity criteria, eliminating authorization for Medi-Cal enrollees that do not require ADHC services to remain in the community;
- Unbundling of the ADHC all-inclusive procedure code and requiring ADHCs to bill only for those specific services provided that were medically necessary;
- Development of prospective costs reimbursement that tie the ADHC rates to the actual costs of providing the services; and
- Intensive and ongoing audits of ADHCs to prevent and resolve fraud and abuse issues.

Background—What Are Adult Day Health Care Services and Baseline Funding Provided in the Medi-Cal Program. Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home. The ADHC Program is funded in the Medi-Cal Program. The DHS performs licensing of the program and the Department of Aging administers the program and certifies each center for Medi-Cal reimbursement.

The baseline budget for the ADHC Program is $407.3 million ($203.6 million General Fund). The average monthly cost per ADHC user is $1,010. The projected average monthly user of these services is about 46,000.

The current reimbursement rate for ADHCs is 90 percent of the nursing facility level A rate. This is a bundled, all-inclusive rate for all ADHC services which was set by a court settlement in 1993. *The baseline budget assumes a 5.15 percent rate increase, prior to the Governor's 10 percent reduction to Medi-Cal rates.*

The Governor's 10 percent reduction, as adopted in Special Session, reduces Adult Day Health Care by $36.4 million ($18.2 million General Fund) from the baseline level.

The bundled reimbursement rate pays for a day of ADHC services (defined as a minimum of four hours, not including transportation) regardless of the specified services actually provided on any given day. The bundled rate assumes that the required ADHC services will be provided to individuals as deemed medically necessary.

Background—Moratorium Continues on New ADHC. Through the Budget Act of 2004 and accompanying trailer bill legislation, a 12-month moratorium on the certification of new ADHCs became effective.

This was done to diminish the growth of the centers due to concerns regarding rapid growth and the potential for Medi-Cal fraud, as well as concerns expressed by the federal CMS regarding the operation of California's program (which SB 1775, Statutes of 2006 address). With minor adjustments, this moratorium was extended for 2005, 2006, 2007 and the budget assumes this continuation through 2008-09. Existing statute makes annual renewal of the moratorium the purview of the Director of Health Services (Director Sandra Shewry).

Legislative Analyst Office Recommendation—Reject Position Request. *First,* the LAO recommends rejecting the DHCS' request for 20 additional state positions. They believe that work on SB 1775 can continue with the resources provided last year and that the Medi-Cal Error Rate Study could be done on a biennial basis (once every two years).

Second, they raise no issues regarding the local assistance adjustments for tightening the medical necessity component of the ADHC Program.

Subcommittee Staff Comment and Recommendation—Approve 1 Position. The DHCS was provided 33 additional positions last year to commence with the reform efforts. Based on recent information, many of these positions are still in the process of being filled.

With respect to the need for more anti-fraud efforts regarding the ADHC Program, the DHCS has considerable Audits and Investigations staff which can be focused and redirected on various aspects of the Medi-Cal Program as needed. There are also many tools that the DHCS can employ with respect to claims review, withholds, suspension of Medi-Cal Provider numbers and various other administrative actions in the event of suspected fraud and abuse. General Fund resources are limited and need to be directed at providing core services to people which the state serves.

Due to the need for the DHCS to develop a federal Waiver for continuation of the ADHC Program, Subcommittee staff recommends approval of one position (Research Analyst II as designated) for this purpose. All other positions should be deleted.

Further, Subcommittee staff concurs with the LAO regarding the approval of the local assistance adjustments regarding the tightening of medical necessity for ADHC services.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. DHCS, Please provide a *brief update* regarding implementation of SB 1775 and the reforms the DHCS is implementing regarding the ADHCs.

2. DHCS, Please provide a *brief update* regarding the Medi-Cal Error Report and concerns identified regarding ADHCs.

3. DHCS, Please provide a *brief summary* of the budget actions, *both* the requested positions and the savings identified in the Medi-Cal budget relating to the tightening of medical criteria.

6. Administration's Trailer Bill Language-- AB 1629 Nursing Home Rates

Issue. The DHCS is proposing trailer bill language to extend for one year the sunset date for this nursing home rate methodology to include the *2009-2010 rate year*. Existing statute continues the rate methodology through to July 31, 2009 presently.

At this time no other statutory changes are proposed. *However* it is likely that the Administration may be proposing additional changes at the May Revision.

The purpose of the enabling legislation was to create a *"facility-specific"* Medi-Cal reimbursement methodology for nursing homes, and to authorize a provider *"Quality Assurance Fee"* to assist in providing a Medi-Cal rate increase.

The purpose of these changes were to devise a rate-setting methodology that: (1) encouraged access to appropriate long-term care services; (2) enhanced quality of care; (3) provided appropriate wages and benefits for nursing home workers; (4) encouraged provider compliance with state and federal requirements; and (5) provided administrative efficiency.

It should be noted that the Administration has yet to conduct a *comprehensive analysis* of the effects of the rate increases. Two studies have been done by not by the DHCS. The most recent study, supported with a foundation grant, is discussed below.

An April 1 report—"Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs--conducted by researchers at the University of CA, San Francisco (Charlene Harrington, PhD, et al) contends that contrary to expectations, the new reimbursement methodology did not substantially improve quality as measured by complaints, licensing and certification deficiencies, staffing levels, turnover rates and wage levels.

Among many other things, the report also notes that 16 percent or 144 nursing facilities in the state did not meet the state's minimum staffing standard of 3.2 hours per resident day in 2006. Therefore, the researchers conclude that California nursing homes have low staffing levels, and average staffing levels only slightly improved after California adopted the new reimbursement system.

Governor's Proposed Budget. Facilities paying Quality Assurance Fees, including all facilities reimbursed as contained in AB 1629, were held harmless from the Governor's 10 percent Medi-Cal rate reductions. The DHCS notes that revenues of $289 million are to be generated from the Quality Assurance Fees in 2008-09. These revenues will be used to offset General Fund expenditures contained within the Medi-Cal Program as designed.

According to the DHCS, an increase of $186.4 million ($93.2 million General Fund) is proposed for 2008-09 to fund the AB 1629 rate methodology and the increase in the state's minimum wage ($8.00 as of January 2008). It should be noted that this level of funding represents a 3.35 percent cost-of-living-adjustment (COLA) which is more than 2 percent below the cap as contained in statute.

Background---Summary of Key Aspects of Assembly Bill 1629, Statutes of 2004.
The key components of the nursing home rate methodology contained in this enabling legislation are as follows:

- Establishes a **baseline reimbursement rate** (weighted average rate) *and* state maintenance of effort level (methodology in effect as of July, 2004 plus certain specified adjustments). The facility-specific rate and "Quality Assurance Fee" rate increases are built upon this baseline.

- Establishes a **"facility-specific" Medi-Cal reimbursement methodology** for nursing homes. Payment is based upon each facility's projected costs for five major cost categories: (1) labor costs; (2) indirect care non-labor costs; (3) administrative costs; (4) capitol costs—"fair rental value system"; and (5) direct pass-through costs (proportional share of actual costs, adjusted by audit findings).

- Imposed a **"Quality Assurance Fee"** on all nursing homes (about 1,200 facilities), not to exceed 5.5 percent as of January 2008, which is deposited in the state treasury and is used to fund the specified rate increases, as well is used to offset some General Fund expenditures (amounts vary each year for the rate increase and General Fund savings levels). (Effective January 2008, the federal government is lowering the 6 percent threshold for fees to 5.5 percent.)

- Limits growth in the overall Medi-Cal reimbursement rate for nursing homes through the use of spending caps. These spending "caps" were agreed to because facility-specific reimbursement systems can be inflationary. The spending "caps" contained in the enabling legislation are:

  - ✓ 2005-06 8 percent (of the weighted average rate for 2004-05);
  - ✓ 2006-07 5 percent
  - ✓ 2007-08 5.5 percent (DHCS states this cap will not be reached)

Constituency Concerns. The Subcommittee is in receipt of several letters regarding this issue with diverse opinions and concerns.

A key theme is that this program area needs to have a *more comprehensive* evaluation as to the quality assurance benefits to resident care which have or have not resulted from this rate methodology.

Another issue pertains to the regulatory establishment of minimum staff-to-patient ratios for direct caregivers and licensed nurses in nursing homes. These regulations were not proposed until late 2007 (legislation was enacted in 2003), as the result of litigation. Emergency regulations were filed with the Office of Administrative on April 15, 2008 and will not be implemented by the DHCS unless funding is provided. At this time an estimate of $208 million in annual costs has been estimated by the DHCS and would be contingent upon appropriation in the Budget Act (very unlikely given the state's fiscal crisis).

Additional issues of concern include nursing home providers expressing the need to maintain their rates to address staffing expenditures to maintain patient care, and other advocates concerned that too much funding is being provided for “institutional” care versus providing community-based care.

<u>Subcommittee Staff Recommendation—Open.</u> It is recommended to hold this issue open until the May Revision.

<u>Questions.</u> The Subcommittee has requested the Administration to respond to the following questions:

1. Why has the Administration proposed to extend the AB 1629 rate methodology through trailer bill language and has not pursed the policy committee process since existing statute continues the rate methodology until June 30, 2009?

2. What is the Administration’s perspective of the UCSF Report?

3. Please provide a brief fiscal summary of the rate increase as contained in the Medi-Cal budget. Will these figures be adjusted at the May Revision?

ISSUES FOR DISCUSSION –DEPARTMENT OF PUBLIC HEALTH

1. Licensing and Certification—Multiple Issues *(“A” through “D“).* The L&C Program develops and enforces state licensure standards, conducts inspections to assure compliance with federal standards for facility participation in Medicare and/or Medi-Cal, and responds to complaints against providers licensed by the DPH.

The budget proposes several adjustments to the Licensing and Certification (L&C) Program within the Department of Public Health (DPH). Due to the complexity of the issues, each of them is discussed separately below.

ISSUE “A”—Governor’s Proposed Fee Increases. Commencing with the Budget Act of 2006, the Governor has *annually* proposed significant increases in the fees paid by health care facilities and agencies (i.e., “Non-State”). State-owned facilities have their licensing and certification fees paid using General Fund support, as well as applicable federal funds.

Through a number of means, the Legislature has annually acted to mitigate the Administration’s substantial fee increases, including requiring improved time keeping systems, the unbundling of facility types to more appropriately allocate costs, adjusting state staffing requirements, recognizing other revenues collected by the L&C Division to offset L&C Fees, and providing a small General Fund subsidy for certain non-profit community-based facilities.

The Governor’s proposed L&C fee increases are shown in the table below, as compared to those approved by the Legislature through the Budget Act of 2007. As noted below, in most instances there are *substantial fee increases* proposed for 2008-09.

Governor’s Proposed Licensing and Certification Fee Schedule Increases

Facility Type	Fee Category	2007-08Fee (Budget Act 2007)	Governor’s 2008-09 Fee	Difference (+/-) *(Rounded)*	Percent Change *(Rounded)*
Referral Agencies	per facility	$6,798.11	$6,216.49	-$582	-8.6%
Adult Day Health Centers	per facility	$4,383.14	$5,030.16	$647	14.7%
Home Health Agencies	per facility	$3,867.14	$5,260.47	$1,393	36%
Community-Based Clinics	per facility	$871.13	$1,349.93	$479	55%
Psychology Clinic	per facility	$2,296.58	$3,565.26	$1,268	55%
Rehabilitation Clinic (for profit)	per facility	$402.20	$1,103.60	$702	172%
Rehabilitation Clinic (non-profit)	per facility	$402.20	$1,103.60	$702	172%
Surgical Clinic	per facility	$2,842.08	$2,694.73	-$148	-5.2%
Chronic Dialysis Clinic	per facility	$3,238.98	$3,405.79	$166	5.1%
Pediatric Day Health/Respite	per bed	$138.30	$195.89	$58	4.2%
Alternative Birthing Centers	per facility	$1,710.20	$2,983.92	$1,274	74.5%
Hospice (2-year license)	per facility	$723.86	$2,221.40	$1,497	206%
General Acute Care Hospitals	per bed	$309.07	$255.46	-$54	-17.5%
Acute Psychiatric Hospitals	per bed	$309.07	$255.46	-$54	-17.5%
Special Hospitals	per bed	$309.07	$255.46	-$54	-17.5%
Chemical Dependency Recovery	per bed	$200.29	$177.49	-$23	-11.5%
Congregate Living Facility	per bed	$250.77	$292.20	$41	16.3%
Skilled Nursing	per bed	$250.77	$292.20	$41	16.3%
Intermediate Care Facility (ICF)	per bed	$250.77	$292.20	$41	16.3%
ICF-Developmentally Disabled	per bed	$469.81	$1,307.72	$837	178%
ICF—DD Habilitative, DD Nursing	per bed	$469.81	$1,307.72	$837	178%
Correctional Treatment Centers	per bed	$806.53	$832.67	$26	3.3%

As required by statute, the DPH did *finally* publish their annual L&C Fees Report in March (over 1 month late), and has provided some additional background to several constituency groups regarding how the fees are calculated.

However, Subcommittee staff notes that information has been more problematic to obtain this year and that several organizations have not yet been provided full disclosure on how their particular heath care category of fees have been determined (as proposed by the Governor).

Based on information gleaned by Subcommittee staff, the following should be noted with respect to the DPH's proposed increases for L&C Fees:

- *Reduction in General Fund Subsidy for Non-State Facilities*. The General Fund subsidy of $2.782 million provided by the Legislature last year has been reduced by the Administration to a total subsidy of $2.340 million (General Fund). The Legislature has been providing a subsidy for certain community-based, non-profit health facilities since inception of the Fee program by the Administration. A decrease in General Fund support means an increase in fees.

  The DPH proposes to use the $2.340 million in General Fund subsidy to offset L&C Fees for the following health care facilities. The DPH did allocate this subsidy in the same proportion as done previously (same percentage as used by the Legislature).

Health Facility	Proposed General Fund Subsidy	Percent of Subsidy
Home Health Agencies	$491,166	21%
Community Clinics	$636,714	27.2%
Psychology Clinics	$12,636	0.54%
Surgical Clinics	$171,522	7.3%
Chronic Dialysis Clinics	$151,866	6.5%
Hospice	$133,380	5.7%
Intermediate Care Facilities (6-bed)	$742,716	31.7%
Total	$2,340,000	100%

- *DPH Provides Price Increase*. The DPH reflects an increase of $478,000 (L&C Fees) to provide its headquarters and field offices with more funding for operating expenses and equipment.

- *DHP Employee Compensation Adjustment*. The DPH reflects an increase of $1.8 million in costs associated with employee compensation adjustments for the budget year.

- *Proposed Augmentation for SB 739 (Speier), Statutes of 2006.* In the Budget Act of 2007, the Governor vetoed an increase of $1.3 million ($833,000 General Fund and $431,000 L&C Fees) for implementation of this legislation. For the budget, the DPH is now proposing an increase of $431,000 (L&C Fees) to fund three positions. The DPH is showing this as a "baseline" adjustment and does not clearly provide reference to this adjustment in its annual L&C Fees Report. Further the DPH allocates the $431,000 across all facility types based on an assumed workload percentage.

- *Proposed Augmentation for Continued Implementation of SB1312 (Alquist), Statutes of 2006.* Though the DPH was provided a total of 16 positions, as requested in the Budget Act of 2007 and the Legislature adopted modifications as requested by the Administration to clarify statute, the DPH is requesting an *additional* $8.864 million (L&C Fees) for 2008-09. The DPH would use these funds to hire an additional 68 positions.

  This issue is discussed separately in this Agenda under *ISSUE "B",* below.

- *Proposed Augmentation for Reviewing and Processing of Applications.* The DPH is requesting an augmentation of $732,000 ($293,000 L&C Fees and $439,000 federal funds) for 7 positions. This issue is discussed separately in this Agenda under *ISSUE "C"*, below.

- *Special Fund Loan Repayment.* In 2006, a loan from the General Fund was established as a transition until the L&C Fee revenues were generated to sustain the program. As such, a loan repayment of almost $1.1 million (L&C Fees) is transferred to the General Fund for 2008-09. This represents the final payment on the loan.

- *Other Revenue Offsets to L&C Fees.* As required through trailer bill language enacted last year by the Legislature, miscellaneous fee revenues such as that collected from "change of ownership" fees and initial application fees will be used to offset a portion of the L&C Fees overall. The DPH estimates that about $3 million in other revenues will be used to offset L&C Fee increases.

- *"Prudent" Reserve Adjustment.* The DPH also includes an increase of $158,000 (L&C Fees) to account for a 5 percent "prudent" reserve in addition to all of the other calculations.

Background—L&C Fee Fund Reserve--$7.3 million Available . The L&C Fee special fund is reflecting an overall fund condition balance of $7.3 million (L&C Fees). This is the reserve for economic uncertainty that is projected for this fund for 2008-09. Subcommittee staff believes that a portion of these reserves could be used to reduce the projected increase in L&C Fees for some of the health care facilities.

Background—Baseline Workload Assumptions. The DPH uses a "workload" methodology which they state is based upon a detailed timekeeping system as to how staff is utilized by the 17 L&C Field Offices in the state to conduct various licensing and certification visits, including initial visits, annual reviews, follow up, visits for complaints and others. Based on this "workload" methodology, a percentage is devised and it is used to then allocate costs back to the individual health care facility categories.

The DPH's "workload" percentage for allocating costs to each category of health care facility for 2008-09 is shown in the table below.

Facility Type	Administration's Workload Percentage
Referral Agencies	0.0722%
Adult Day Health Centers	2.1262%
Home Health Agencies	7.4880%
Community-Based Clinics	2.3347%
Psychology Clinic	0.1059%
Rehabilitation Clinic (for profit)	0.1661%
Rehabilitation Clinic (non-profit)	0%
Surgical Clinic	2.4468%
Chronic Dialysis Clinic	1.9938%
Pediatric Day Health/Respite	0.0429%
Alternative Birthing Centers	0.0173%
Hospice (2-year license)	0.9590%
General Acute Care Hospitals	23.6436%
Acute Psychiatric Hospitals	23.6436%
Special Hospitals	23.6436%
Chemical Dependency Recovery	0.0868%
Congregate Living Facility	40.7132%
Skilled Nursing	40.7132%
Intermediate Care Facility (ICF)	40.7132%
ICF-Developmentally Disabled	17.0882%
ICF—DD Habilitative, DD Nursing	17.0882%
Correctional Treatment Centers	0.7161%

It should be noted that many constituency groups are still unclear as to how this workload percentage is devised, and they are concerned since it is a key aspect of how the L&C Fees are calculated. As noted below, the Office of Statewide Audits and Evaluations (OSAE) also raised this issue.

Background--Office of Statewide Audits and Evaluations Report: Licensing and Certification Fees Methodology Review. Due to continued concerns expressed by the Legislature regarding the Administrations development and application of fees under this program, the Legislature requested the Office of Statewide Audits and Evaluations (OSAE) within the Department of Finance to conduct an analysis of the methodology used by the DPH. The DPH's methodology is critical because it services as the baseline for developing the "workload" percentages (baseline costs) as noted above.

The OSAE report, released on January 31, 2008, made the following key points regarding the L&C Fee methodology used by the DPH:

- The DPH *cannot ensure* that the L&C Fees to be assessed to health facilities in 2008-09 will fairly allocate the costs among the various health facilities;

- The DPH has design flaws and operational weaknesses in its timekeeping system used by the L&C Division for determining workload allocations;

The OSAE then made the following recommendations for improvement:

1. Modify the existing timesheet format;
2. Develop written procedures for the Headquarters timesheet adjustment process;
3. Provide training to staff on usage of the format and related administration;
4. Reconcile the timesheet data to the accounting data on a monthly basis;
5. Maintain adequate supporting documentation to support all data used to calculate the L&C Fees.

At this time it is not clear to Subcommittee staff if the DPH has *fully* implemented all of these OSAE recommendations, or if the DPH is making other additional improvements in this area.

Continued Vacancies in Licensing and Certification—Very Significant. According to the DPH, as of January 2008, the L&C Division had a total of *167 vacant positions*. Of this vacancy level, a total of 96 positions (57 %) pertained to the Health Evaluator classifications which are the key positions used in conducting licensing and certification surveys. Many of the other vacancies pertain to pharmacy consultants, program technicians and other key support staff.

Subcommittee staff would note that the L&C Division is still in transition for making improvements. A significant number of positions have been added to the Division over the past several years on a bi-partisan basis in an effort to improve oversight and the quality of patient care through out the health care facilities system. The large number of staffing increases, coupled with personnel shortages in many areas, including nursing, has proven to create a hiring challenge for the DPH.

However, an update at the May Revision on their vacancy levels would be useful prior to adding additional positions (as discussed in the issues noted later in this Agenda).

L&C Division's Use of Lower Hours for Staff Calculations. As discussed for the past two-years in Subcommittee, the DPH uses a Health Facility Evaluator Nurse (HFEN) surveyor workload calculation of 1,364 personnel hours as being a full-time equivalent position. Most other programs within the DPH, as well as state departments pervasively, use a calculation of 1,800 personnel hours, or 336 hours more, as their full-time equivalent.

Therefore, each HFEN position at the DPH represents *25 percent less time* than other full-time equivalent positions.

The DPH has used this calculation due to the need for training time, completion of reports and related aspects of the surveyor position. However, Subcommittee staff believes that this enriched level should now be changed back to the 1,700 level on a prospective basis for all future positions as calculated for budgetary purposes. The baseline needs for the L&C Division have improved from an overall staffing position perspective and new positions can be added at the standard state personnel hours equivalent.

Subcommittee Staff Comment and Recommendation—Some Actions Now. *First,* as already noted, it has been more problematic this year to obtain information regarding the many of the details as to how the L&C Fees are calculated. Further, appropriate public access to this information is not readily available since much of the information is not contained in the annual L&C Fee Report as required by statute.

Therefore, it is recommended to adopt placeholder trailer bill legislation to require the DPH to provide a brief narrative of all baseline adjustments *and* dollar amounts assumed for calculation of the L&C Fees, including the basis for its workload assumptions and a comparison of the prior year's L&C Fees (i.e., 2007-08 in this case) with the baseline L&C Fees for the budget year (i.e., 2008-09). This information would be contained in the annual L&C Fee Report..

Second, it is recommended to *delete* the DPH's funding augmentation of about $500,000 for the "price" adjustment related to operating expenses and equipment and related items. Cost-of-Living-Adjustments are not being given to most programs and this augmentation just increases the L&F Fee level.

Third, the L&C Fee special fund reserve is at $7.3 million (L&C Fees). Subcommittee staff believes that a portion of these reserves could be used to reduce the projected increase in L&C Fees for some of the health care facilities. The DPH should provide the Subcommittee with an updated Fund Condition Statement on these reserves at the May Revision.

Fourth, Subcommittee staff is concerned with the vacancy rate of the L&C Division. But because of it, there will be additional *unspent* L&C Fees (i.e., collected fees not being spent on staff). As such, the L&C Division should provide this information at the May Revision, once an update on filling staff can be obtained. Unspent L&C Fees can be used to offset 2008-09 L&C Fee increases as presently proposed by the Governor.

Fifth, Subcommittee staff recommends the adoption of the following Budget Bill Language regarding the use of the 1,700 hours equivalent for all of the DPH positions related to the

Licensing and Certification Division. This language will be applicable for one-year and can be modified next year if needed. The proposed language is as follows:

> Item 4265-001-0001
> Provision x. The Department of Public Health shall use the standard state personnel year equivalent for all new positions funded in 2008-09 for licensing and certification activities related to health care facilities.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. DPH, Please provide a brief summary of the Administration's L&C Fee increases.
2. DPH, Please *briefly* explain how the "workload" baseline is calculated.
3. DPH, Please *briefly* explain what is being done to fill vacant positions?
4. DPH, Please *briefly* explain the *key actions* taken to address concerns expressed in the Office of State Audits and Evaluations report.

ISSUE "B"—Licensing and Certification Increases Senate Bill 1312 (Alquist), 2006

Issue. The DPH is requesting an increase of $8.7 million (L&C Fees) to support 68 state positions and augment a contract the state has with Los Angeles County (as is always done), to continue implementation efforts associated with SB 1312 (Alquist), Statues of 2006. The amount for the Los Angeles County contract is $985,000 (L&C Fees).

Of the requested positions, 51 are Health Facilities Evaluator Nurses (HFEN), 7.5 are Supervising HFEN and the remaining positions provide quality assurance, training, data analysis and technical support to the surveyors.

The DPH states that this position request is based on L&C developed and pilot tested survey tools and an analysis of the state standards and required survey work. They state that that the pilot tests indicate the workload hours have increased considerably from the initial estimates and the appropriation provided in the Budget Act of 2007.

The table below outlines the request for the HFENs who would conduct the survey work. Stand-alone surveys means the survey will be performing the survey at a separate time from the federal re-certification surveys. Concurrent survey means that will be done at the same time (federal certification and state review).

Facility Type	**"Stand Alone" Surveys**	**"Concurrent" Surveys**	**Total HEFNs**
Nursing Homes (one to 90 beds)	238	79	17.0
Nursing Homes (91 plus beds)	247	83	33.0
Adjustment for 10 Positions (Budget Act of 2007)			-10.0
Totals	**647 surveys**	**162 surveys**	**40.0**

Key assumptions used to develop this workload estimate are as follows:

- A state re-licensing survey is required at least once every two years. About 50 percent of the licensed long-term care health facilities will be surveyed each year. The remaining 50 percent would be surveyed on alternate years.
- It is estimated that 42 percent of those facilities surveyed in the prior year will require an annual survey based on citation data from L&C's system (between October 2006 to October 2007). About 192 surveys will be needed to address this area.
- "Concurrent" surveys will require a total of 6 HFENs while "stand alone" surveys will require 40 additional HFENs. Therefore, a total of 46 are needed for these efforts.
- The total number of surveys to be completed by the DPH in 2008-09 is 647 surveys. Los Angeles County will complete 409 surveys under their stand-alone contract.

As part of the 68 position request, the DPH is also requesting 6 positions to do "quality assurance reviews" as part of this process. Quality assurance reviews reassure that patient safety is protected and will provide standardization across the state so that evaluators in the Field Offices are applying and enforcing state standards.

Lastly, 5 other positions have been identified to address significant training needs and continuing education to staff.

Background--Budget Act of 2007. A total of 16 positions, including ten surveyor positions were provided to the DPH to begin implementation efforts. In addition, trailer bill language was adopted at the Administration's request to provide further clarification regarding implementation of SB 1312.

Background—Senate Bill 1312 (Alquist), Statutes of 2006. Prior to the passage of SB 1312, long-term care health facilities that were certified to participate in the Medi-Cal Program were *exempt* from periodic state licensing inspections. SB 1312 removed that exemption.

SB 1312 requires the DPH to inspect all licensed long-term care health facilities to ensure compliance with state laws and regulations to the extent that those standards provide greater protection to residents or are more precise than federal standards. All long-term care health facilities must be surveyed once every two years. However, a long-term health facility that has received a class "AA", "A" or "B" citation for non-compliance with state law or regulation within the last 12 months must be surveyed annually.

To ensure maximum effectiveness of inspections conducted, SB 1312 also mandated the L&C Division to identify all state law standards for staffing and operation of long-term care health facilities.

Background—Federal and State Aspects. The survey protocols for conducting a federal *certification* survey are prescribed by the federal CMS. The DPH surveyors are "graded" for compliance with those protocols by periodic and direct observations by the federal CMS specialists. The DPH performance is measured by the average length of time taken for the federal survey, the timeliness of submitting the survey findings to the facility, and the timeliness of obtaining an acceptable plan of correction.

The federal CMS does *not* permit violations of *state licensing* standards to be included in the federal certification survey documents. Failure to comply with federal standards can jeopardize the federal grant funds the state receives for the L&C Division.

Allocation of Staff Expenditure for L&C Fee Purposes. With respect to the L&C Fee methodology for allocating the costs of this staff, it should be noted that the DPH is spreading the $8.7 million (L&C Fees) across the following health care facility categories:

- Pediatric Day Health/Respite Care — $ 9,104
- Skilled Nursing, and Intermediate Care Facility — $6.3 million
- Intermediate Care Facilities for Disabled — $2.5 million

Constituency Concerns with Implementation. The Subcommittee is in receipt of a letter from consumer advocates who are in support of the L&C Division's funding request for positions, but are seeking clarity in how the DPH is actually proceeding with implementation of SB 1312 on a statewide basis.

Of key importance is the need for the DPH to implement SB 1312 on a statewide basis. Thus far there has been limited implementation even though the law took effect on July 1, 2007. A key aspect of this concern is that the DPH has not provided any written instructions to its Field Offices on how to evaluate compliance with the SB 1312 requirements during licensing inspections. Apparently each surveyor is left to choose his or her own approach for evaluating and documenting compliance and to setting priorities for the licensing components of the surveys.

Subcommittee Staff Comment and Recommendation—Modify and Leave Open.
First, it is recommended for the DPH to submit a revised proposal using the standard state productivity hours of 1,800 annually, versus the 1,364 personnel hours as presently being used. The calculation needs to be provided to Subcommittee staff *before* the May Revision.

As discussed under ISSUE "A", the DPH is one of the only departments in state government using this lesser standard. Further, with the inclusion of the quality assurance reviews and the additional staff for training, as contained in this request, the HEFNs should be able to begin to meet program goals. This can be monitored and reviewed in subsequent budgets.

Second, Subcommittee staff is equally concerned with the lack of instruction from the DPH to its Field Offices regarding the implementation of SB 1312. In a written response to questions, the DPH notes that seven (7) of its 17 Field Offices use the federal enforcement process where substantiated complaints are assessed a federal "scope and severity" finding for the facility. While the ten (10) other Field Offices follow the state requirement process whereby substantiated compliant and facility reported events may result in a state citation.

The DPH needs to clarify why it is proceeding in this manner and if it is creating any quality assurance concerns across the Field Offices.

Questions. The Subcommittee has requested the DPH to respond to the following questions.

1. DPH, Please provide a brief summary as to how the DPH conducts its surveys to meet the requirements of SB 1312.
2. DPH, Please provide a brief summary of the budget request.
3. DPH, Please clarify how the state intends to fully implement SB 1312 requirements statewide and why there are differences between Field Offices in the manner referenced above.

ISSUE "C"—Licensing and Certification: Professional Certification Branch Staff

Issue. The DPH is requesting an increase of $732,000 ($293,000 L&C Fees and $439,000 federal funds) to fund 7 state positions to investigate complaints against Certified Nurse Assistants (CNAs), Home Health Aides and Certified Hemodialysis Technicians who are accused of abuse, theft, negligence, or unprofessional conduct against patients in health care facilities, private homes or agencies.

The DPH states these positions are needed due to an increase in new complaints received and the importance of addressing a backlog of 726 cases. Specifically, 1,458 new complaints were received in 2006-07. This large volume of new complaints, coupled with 629 existing cases being investigated, combined for a total of over 2,000 cases.

Though DPH staff has been working diligently, an increase in staff is requested to alleviate the existing backlog needing review of 726 cases. Currently 15 staff are performing these investigations and related work.

The DPH notes they have triaged the new complaints into three priorities:

(1) Abuse (sexual and physical assault, sexual coercion, emotional abuse and theft). About 55 percent of the complaints are in this category.

(2) Negligence and Unprofessional Conduct (rough handling, poor care, dropping a resident resulting in injury, and abandonment). About 34 percent of complaints are in this category.

(3) Certification by Fraud or Misrepresentation (identification, theft, stolen/false social security number, perjury on application for certification, and competency testing fraud). About 11 percent of complaints are in this category.

Allocation of Staff Expenditure for L&C Fee Purposes. With respect to the L&C Fee methodology for allocating the costs of this staff, it should be noted that the DPH is spreading the $293,000 in L&C Fee expenditures across all health facility categories using the workload percentage as discussed in ISSUE "A", above.

Background—Overview of Investigation Process. The "Professional Certification Branch" within the L&C Program is responsible for oversight of the CNAs, Home Health Aids and Certified Hemodialysis Technicians. The branch receives complaints against these professions from health care facilities or agencies, the State Long-Term Care Ombudsman, victim's families, L&C Field Offices, and law enforcement agencies.

Investigators work primarily in the field, interviewing complainants, victims and witnesses; reviewing medical, financial and criminal records; developing investigative leads; and collecting, securing and interpreting evidence. In the office the investigators document case findings and recommend disciplinary actions.

When the complaint is of a criminal nature, the investigators work with local law enforcement, the Department of Justice and other agencies. Investigators also testify as expert witnesses in criminal cases filed by local prosecutors and the Department of Justice.

Subcommittee Staff Recommendation--Approve. Subcommittee staff concurs with the workload and need for these positions. This backlog creates potential health and safety concerns.

Questions. The Subcommittee has requested the DPH to respond to the following questions.

1. DPH, Please provide a brief summary of the budget request and an update on the investigation of the backlog.

ISSUE “D”—Licensing and Certification: Governor’s Reduction

Issue. The Governor is proposing a reduction of $1.254 million (General Fund) to the L&C Program as part of his 10 percent reduction proposal.

The DPH states that this reduction amount will be taken as follows:

- *General Fund Subsidy to Offset L&C Fee Costs.* A reduction of $260,000 (General Fund) is proposed by reducing the amount of the General Fund subsidy provided to certain health care facilities form its current $2.6 million in 2007-08 to a total of only $2.3 million in 2008-09. (As discussed under ISSUE “A” above).
- *State Facilities Surveys.* A reduction of $918,000 (General Fund) is proposed by eliminating five of thirty-two Health Facilities Evaluator Nurse positions who survey state facilities (such as the state Developmental Centers, State Hospitals and Veterans Homes)
- *Administrative Overhead.* A reduction of $54,000 is proposed by decreasing the amount of distributed administrative overhead allocated to the L&C Program.

Subcommittee Staff Comment and Recommendation—Modify the Reduction. In order to achieve the same level of General Fund reduction as proposed by the Governor, it is recommended to further reduce the State Facilities Unit by two positions and to make adjustments to the operating expense and equipment area of the overall L&C Division to achieve the $260,000 (General Fund) reduction, in lieu of reducing the General Fund Subsidy to offset L&C Fees.

Questions. The Subcommittee has asked the DPH to respond to the following question.

1. DPH, Please comment on the Governor’s proposed reduction.

2. Governor's Proposed Reduction to Battered Women Shelter Program

Issue. The Governor is proposing a reduction of almost $2.7 million (General Fund) to the Battered Women Shelter Program. This reduction would reduce all of the shelter grants (total of 94) and four technical assistance and training contracts by about 10 percent. The reduction to the shelters would mean that 13,000 women would *not* receive program services.

This core public health and safety program is presently funded at $22.9 million ($22.6 million General Fund and $235,000 Domestic Violence Training and Education Fund) and funds 94 shelter-based domestic violence agencies to provide emergency and non-emergency direct services to battered women and their children and to perform domestic violence prevention activities.

Shelter services include emergency shelter, transitional housing, legal advocacy and assistance with temporary restraining orders, counseling, and other support services.

The Battered Women Shelter Program grantees serve about 130,000 women and their children each year (105,000 women and 25,000 children) with the existing funding level.

Office of Emergency Services Domestic Violence Programs. The OES has a total of $2.5 million (General Fund) which is also allocated certain domestic violence shelters.

Legislative Analyst's Office Recommendation—Reject Proposed Reduction. The LAO recommends rejecting this proposal since it affects direct services that provide for immediate public health and safety concerns.

Subcommittee Staff Comment and Recommendation. Subcommittee staff concurs with the LAO recommendation that services provided under the Battered Women Shelter Program address immediate public health and safety concerns for women, children and related family members.

Questions. The Subcommittee has requested the DPH to respond to the following question.

1. DHCS, Please provide a brief summary of the reduction proposal and the potential impacts to services.

3. Trailer Bill Legislation—Continued Oversight of New Department

Issue. With the creation of the new Department of Public Health (DPH) in July 2007, issues have come to the forefront regarding the continued evolution of the restructuring efforts.

Many of these issues pertain to the natural outgrowth of creating a new state department, and some of them concern issues that have not had the opportunity to be fully vetted before due to the shear size and complexity of the Department of Health Services prior to the split into the two very distinguishable departments.

With appointments just completed for the 15- member Public Health Advisory Committee, it appears to be an opportune time to propose trailer bill legislation to continue the restructuring efforts in a more focused manner to address specific administrative and programmatic efficiencies.

For example, the Legislative Analyst states in her Analysis that consideration of consolidating various public health programs into a block grant might be warranted. Subcommittee staff believes a more comprehensive review of certain administrative functions, such as development of program regulation packages, is much over due for public health programs.

Therefore, Subcommittee staff is recommending adoption of the following trailer bill language to more fully engage the Public Health Advisory Committee and DPH to continue the restructuring efforts to ensure the sustainability of core public health programs.

<u>Proposed Trailer Bill Language (uncodified)</u>

a) The Director of the Department of Public Health shall convene the Public Health Advisory Committee established by Section 131230 of the Health and Safety Code to review the organizational structure of the Department of Public Health in order assess the department's efficiency and effectiveness in administering its programs. The department shall participate in this review and shall make available to the committee information that is deemed necessary to carry out this review and shall provide support and assistance to the committee within its existing resources.

b) The review shall consider the following:

   i) The ability of the department to carry out current statutory responsibilities.

   ii) The timeliness of program implementation after enactment of statutes, including the development of related regulations.

   iii) The use of fees charged for program services, including the efficiency of collection and budgeting of these fees to carry out the purposes of Department's programs.

   iv) The level of administrative support provided to carry out program services, including the ability to process, in a timely manner allocations, grants and contracts.

   v) The ability to recruit and properly compensate the professional personnel necessary to carry out department programs.

   vi) The organizational structure of the department and the number and breadth of programs administered by the department.

vii) The recommendations by the legislative analyst, as outlined in the Analysis of the 2008-09 Budget Bill, calling for the consolidation of public health programs and the development of a universal contract for funds allocated to local jurisdictions and non - profits organizations.

c) The director and the advisory committee shall seek and invite the participation of experts from local health departments, universities, health providers and organizations that participate in department programs, and the federal government in order to assist and inform the advisory committee in this review.

d) The committee shall report the results of the review required by this section to the director, the Secretary of the Health and Human Services Agency, and to the fiscal committees and the health policy committees of the Legislature by October 1, 2009. The report shall include any recommendations to improve the department's organizational structure, program effectiveness and efficiency, and technical competence and expertise.

<u>Background—New CA Department of Public Health.</u> Effective July 1, 2007, pursuant to Senate Bill 162 (Ortiz), Statutes of 2006, specific programs and public health responsibilities currently vested with the Department of Health Services were transfer to the newly established Department of Public Health (DPH).

The creation of a separate DPH is intended to elevate the visibility and importance of public heath issues. It is also intended to result in increased accountability and improvements in the effectiveness of DPH programs the Department of Health Care Services programs by allowing each department to administer a narrower range of activities and focus on their respective core missions

The core functions of the DPH include: (1) Emergency Preparedness; (2) Communicable Disease Control; (3) Chronic Disease and Injury Prevention; (4) Laboratory Sciences; (5) Family Health Programs; (6) Environmental and Occupational Health; (7) Drinking Water and Environmental Management; (8) Food, Drug and Radiation Safety; (9) Health Statistics; (10) Health Facility Licensure and Certification; (11) Office of Multicultural Health; and (12) Office of Binational Border Health.

<u>Background--Public Health Advisory Committee</u>. A 15-member Public Advisory Committee (Committee) was established in the enabling legislation. Its members are appointed by the Governor (9 appointments), the Senate Rules Committee (3 appointments) and the Speaker of the Assembly (3 appointments). The Committee membership was formally announced in early April.

The purpose of the Committee is to provide expert advice and make recommendations on the development of policies and programs that seek to prevent illness and promote the public's health.

The Committee is to identify strategies to improve public health program effectiveness, identify emerging public health issues, and make recommendations, as necessary, on programs and policies to improve the health and safety of Californians.

<u>Questions.</u> The Subcommittee has requested a response to the following questions.

1. **LAO**, Would you please comment on the proposed trailer bill language?

2. **DPH,** Would you please comment on the proposed trailer bill language?

4. Augmentation for Richmond Laboratory Capital Outlay Project

Issue. The Administration is proposing an augmentation of $2.5 million (General Fund) for the construction of modifications at the Viral and Rickettsial Disease Laboratory which is part of the DPH's Richmond Laboratory complex.

The DPH states that changes are desired for this laboratory to meet newly established guidelines for *"enhanced"* bio-safety Level III laboratories as determined by the U.S. Department of Agriculture, federal Centers for Disease Control and Prevention (CDC) and National Institutes for Health (NIH).

The DPH contends that compliance with these *"enhanced"* guidelines is essential for the safe growing, handling and examining of potentially high pathogenic influenza viral agents, thereby continuing the state's ability to respond quickly and control a potential outbreak of pandemic flu.

Presently the Viral and Rickettsial Disease Laboratory meets bio-safety Level III preparedness but not the new "enhanced" level.

Subcommittee Staff Comments and Recommendation—Defer Proposal for One-Year. As noted the "enhanced" guidelines are relatively new. According to the DPH, there presently are no states in the nation that meet "enhanced" guidelines.

The only laboratories certified to safely handle the Avian ("bird") Influenza viruses is the federal CDC laboratories located in Atlanta, Georgia; Ames, Iowa; and Fort Collins, Colorado.

The DPH states that in the event a case of Avian Influenza is suspected here in California, the general protocol is to use the federal CDC laboratories to conduct confirmatory testing.

Further, the DPH states where there have been two known instances where potential Influenza samples were sent to the federal CDC by the DPH for confirmation. *In both instances, the initial testing was conducted at the Richmond Laboratory complex with the federal CDC conducting the confirmatory analysis.*

Finally, the Administration notes that no other funding sources—federal or special funds—can be identified to be expended for this purpose.

In light of the state's severe fiscal crisis, and the availability of federal CDC "enhanced" bio-safety Level III laboratories to California for the specified purposes, it is recommended to defer this construction for one-year.

ISSUES FOR DISCUSSION –DEPARTMENT OF MENTAL HEALTH

1. Administrative Headquarters Savings—Open Issue

Issue and Prior Subcommittee Hearing—March 14th. In the March 14th hearing, the Subcommittee discussed a comprehensive report by the Office of State Audits and Evaluations (OSAE) within the Department of Finance.

Specifically, this "internal control review" of the Department of Mental Health (DMH) encompassed headquarters operations, as well as the State Hospitals administered by the DMH. The OSAE identified areas where managerial and fiscal controls are not in place or working as intended.

This OSAE report identifies fundamental concerns with core fiscal and administrative functions at the DMH. Their review identified weak budgetary controls, lack of communication and coordination, and weak fiscal oversight among units. They noted that due to weak fiscal oversight, the DMH has not effectively or timely prevented or detected budgeting and accounting errors which have resulted in lost opportunities to fund critical needs.

The OSAE provided the DMH with a series of recommendations (numerous pages) to assist the DMH management in focusing attention on strengthening internal controls, preventing and mitigating risks, and improving operations. *Further, to strengthen controls, OSAE recommended for the DMH to develop a plan to address the observations and recommendations noted in the report.*

The OSAE identifies several areas where General Fund moneys were inappropriately utilized. With improved controls, savings should be achieved.

Request of Senator Alquist, Chair. At the request of the Chair, the DMH was to report back on April 28th to identify General Fund savings within the Headquarters office that can be achieved from re-tooling efforts as suggested by the OSAE report.

In addition, the DMH was directed to provide the Subcommittee with their plan, as recommended in the OSAE report, upon its completion (whenever that occurs).

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. DMH, What level of General Fund savings can be achieved in 2008-09 due to changes which are to occur as suggested by the OSAE report?
2. DMH, When will the DMH have its plan of action completed?

2. County Purchase of State Hospital Beds—Open Issue

Issue and Prior Subcommittee Hearing. In the March 24th hearing, the Subcommittee raised the issue of the state's continued use of General Fund support for State Hospital beds purchased by County Mental Health Plans (County MHPs) for civil commitments.

Specifically, the Department of Mental Health (DMH) provides about $9.8 million (General Fund) to subsidize, or to offset the full cost of, the State Hospital beds purchased by County MHPs.

County MHPs purchase State Hospital beds from the DMH on a contracted basis. According to the DMH's budget, it is estimated that County MHPs will contract for a total of 542 beds (i.e., "Civil Commitments") in 2008-09.

Counties purchase State Hospital beds using their County Realignment Funds (Mental Health Subaccount). Under realignment, counties may choose to purchase State Hospital beds or to utilize community-based resources as appropriate for the individual patient.

During the mid-1990's, the DMH provided some General Fund support to counties to offset the high cost of State Hospital beds while counties were developing community-based resources, including crisis intervention services and more expansive continuum of care services. As community-based resources were expanded, the counties purchased fewer State Hospital beds over time.

Subcommittee Staff Comment and Recommendation. During the mid-1990's General Fund augmentations were provided for several years to assist in offsetting the high cost of State Hospital beds to enable counties to purchase beds as necessary for patient care.

However, with the development over time of community-based resources, and the state's present fiscal situation, the state should eliminate the $9.8 million (General Fund) subsidy for counties. Without the General Fund subsidy, County MHPs may choose to purchase a State Hospital bed at full cost, utilize other long-term care resources, access other community-based resources, or develop new treatment models for patients.

It is recommended to eliminate the $9.8 million General Fund subsidy for the purchase of State Hospital beds and to increase by $9.8 million Reimbursements (coming from County Realignment for the State Hospitals.

Questions. The Subcommittee has the following questions.

1. **DMH**, Any additional comment here?

3. Ancillary Health Services for Patients in Institutes for Mental Disease

Issue. Subcommittee staff believes there is a need for clarifying responsibilities for patients receiving mental health treatment in Institutes for Mental Disease facilities (IMDs).

This is a cross-over issue between the Department of Mental Health (DMH) and the Department of Health Care Services (DHCS). The DMH is responsible for the administration of public mental health programs and the DHCS is the state's Medicaid (Medi-Cal in California) agency.

With respect to the DHCS Medi-Cal budget, the state is presently *repaying* the federal government for improperly claimed federal funds for ancillary health services for Medi-Cal enrollees residing in IMD facilities. Specifically, the Medi-Cal budget reflects General Fund expenditures of $36 million for 2007-08 and $12 million for 2008-09 for the repayment to the federal government for these ancillary health services due to the IMD federal exclusion. The payment for 2008-09 reflects the last payment owed to the federal government at this time.

Subcommittee staff contends that these federal audit exceptions, and therefore General Fund expenditures, should cease once the state has repaid the federal government for past years owed. To ensure that this occurs, additional clarity should be provided in statute and communication between the DMH and DHCS regarding the exchange of data needs to improve.

As noted in the background section below, services provided to most individuals residing in IMDs are generally *not* eligible for federal matching funds as is normally available under the Medi-Cal Program. This includes specialty mental health services, *as well as* ancillary health services (i.e., services that are health-related but not for the treatment of the specific mental illness, including expenditures for pharmacy, laboratory services, and physician services)

On page 4 of a November 2002 letter from the DMH (Letter # 02-06) to Counties, it is stated that County MHPs are responsible for submitting reports to the DMH regarding Medi-Cal enrollees in the IMDs. The IMD report is to be used by the DHCS to identify claims for *all* services that fall under the IMD federal exclusion. County MHPs are responsible, to the extent possible, to prevent the submission of claims to the state for services provided to Medi-Cal enrollees covered by the IMD federal exclusion.

The DMH Letter notes that County MHP inappropriate claiming of federal funds must be minimized in the Medi-Cal system and that individual claiming errors will be subject to disallowance. Further the letter directs for County MHPs that have the capability of editing claims for IMD status and age of enrollee must do so. County MHPs that do not have this capability should be especially careful to report enrollees in the IMDs accurately on the IMD report.

Subcommittee staff contends that more comprehensive oversight by the DMH and DHCS would have improved the data received from County MHPs and would have mitigated the repayment amounts owed to the federal government for these audit exceptions. (The

Office of State Audits and Evaluations noted the need for much improved communication between the two departments in their review of the Medi-Cal Mental Health programs.)

<u>Background—What is an Institute for Mental Disease (IMD)?</u> As defined in a November 2002 letter from the Department of Mental Health to Counties, Institutes for Mental Disease are "a hospital, nursing facility, or other institution of *more than* 16-beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Generally, this includes the following facilities: Acute Psychiatric Hospitals, Psychiatric Health Facilities, Skilled Nursing Facilities with a certified special treatment program, and Mental Health Rehabilitation Centers.

<u>Background—What is the Federal IMD Exclusion?</u> Federal Medicaid law (Medi-Cal in California) states that federal funds are *not* available for individuals under the age of 65 who are patients in an Institution for Mental Disease unless they are under age 22 and are receiving inpatient psychiatric services as specified. This federal exclusion has been in existence since inception of the Medicaid Program. California and many other states have attempted to get this federal exclusion changed for decades with no success.

<u>Background—Counties Responsible for Individuals in IMD's.</u> The Department of Mental Health, in their November 2002 letter to Counties, notes that County Mental Health Plans (County MHPs) are responsible for services to eligible patients. Specifically, this letter states the following:

> "Regardless of whether or not federal financial participation is reimbursed, certain specialty mental health services must be provided to eligible patients by County MHPs under California law and the provisions of their contract with the DMH. Psychiatrist and psychologist services and comparable mental health services and medication support services are the responsibility of the County MHPs in accordance with medical necessity criteria that apply to all other services."

Further, Section 14053.1(a) of the Welfare and Institutions Code states: "ancillary outpatient services, pursuant to Section 14132, for any eligible individual (i.e., for public mental health services) who is 21 years of age or over, and has not attained 65 years of age and who is a patient in an IMD shall be covered regardless of the availability of federal financial participation."

<u>Subcommittee Staff Comment and Recommendation.</u> In order to mitigate General Fund exposure due to any federal audit exceptions related to the IMD federal exclusion, it is recommended to adopt the following trailer bill language:

> "As federal financial participation reimbursement is not allowed for ancillary services provided to persons residing in facilities that have been found to be Institutions for Mental Disease, and since, consistent with Part 2 (commencing with Section 5600) of Division 5 and Chapter 6 (commencing with Section 17600) of Part 5 or Division 9 of the Welfare and Institutions Code, counties are financially responsible for mental health services and related ancillary services provided to persons through county mental health programs when Medi-Cal reimbursement is not available, when it is determined that Medi-Cal reimbursement has been paid for ancillary

services for residents of IMDs, both the federal financial participation reimbursement and any state funds paid for these ancillary services provided to residents of IMDs shall be recovered from counties by the Department of Mental Health in accordance with applicable state and federal statues and regulations."

The above language will more comprehensively compel the DMH to provide increased oversight of County MHPs with this issue and should overall encourage more of a coordinated state effort.

Questions. The Subcommittee has requested the Administration to respond to the following questions.

1. Administration, Please comment on the proposed trailer bill language.

4. Proposition 63—Mental Health Services Act Implementation

Issue. The Subcommittee is in receipt of a Finance Letter requesting several adjustments for the Department of Mental Health pertaining to continued implementation of the Mental Health Services Act (MHSA). A total increase of $32.9 million (MHSA Funds and matching federal reimbursements) is requested for 2008-09. This includes: (1) $5.8 million for state operations (DMH and the Oversight Commission); and (2) $27.2 million for local assistance.

(It should be noted that a discussion regarding funding for the MHSA Housing Program as referenced in the Finance Letter will be conducted at a later Subcommittee hearing.)

Key components of the Finance Letter request are as follows:

- *Workforce Education and Training.* The MHSA requires the development of a program intended to remedy the shortage of qualified individuals providing services to severely mentally ill people. Using data submitted by counties and key stakeholders, the DMH is finalizing a five-year plan based upon a statewide workforce needs assessment. To this end, contract funds are requested for the following: (1) Psychiatric Residency Programs ($1.350 million); (2) Stipend Programs ($10 million); and (3) Client and Family Member Technical Assistance Center ($800,000)

- *Prevention and Early Intervention—Office of Suicide Prevention.* The DMH is requesting a total of four positions ($370,000) to establish an Office of Suicide Prevention and to contract for statewide initiatives regarding suicide prevention ($7 million). Additional funding in this effort also includes: (1) $900,000 for a statewide resource center on suicide prevention; (2) $2.3 million for crisis lines; and (3) $1.5 million for support training and workforce enhancements to prevent suicide.

- *Prevention and Early Intervention—Student Mental Health Initiative.* An increase of $8 million is identified for the provision of mental health services in educational settings throughout the state. A grant program to award about 56 higher education grants to support training, mental health education, peer support and violence prevention would be implemented.

- *Mental Health Services Oversight and Accountability Commission (Commission).* An increase of $842,000 (MHSA Funds) is requested to support two new positions—a Staff Counsel III and a Consulting Psychologist is requested, along with funds to contract out for subject matter experts.

Background—Summary of Key Aspects of Mental Health Services Act (Proposition 63 of 2004), including Local Assistance Funding. The Mental Health Services Act (Act) addresses a broad spectrum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system. It is intended to expand mental health services to children and youth, adults and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most of the Act's funding will be provided to County Mental Health programs to fund programs consistent with their approved local plans. The Act provides for a *continuous appropriation* of the funds to a special fund designated for this purpose.

The Act requires that each County Mental Health program prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health (DMH) after review and comment by the Mental Health Services Oversight and Accountability Commission (OAC).

The Act imposes a 1 percent income tax on personal income in excess of $1 million. The Act is projected to generate (i.e., revenues) about $1.363 billion in 2005-06, $1.528 billion in 2006-07, and $1.694 billion in 2007-08.

The six components and the required funding percentage specified in the Act are as follows:

Six Components of MHSA Act	**2008-09**
Community Services & Supports	55%
Workforce Education & Training	10%
Capital Facilities & Technology	10%
State Implementation/Admin	5%
Prevention and Early Intervention	20%
Innovation (within the Community Services & Supports and Prevention components)	
TOTALS	100 %

<u>Background—Fiscal Policy Clarification and Local Assistance Funding.</u> In December 2007, the DMH states that it revised and clarified many of the MHSA fiscal policies in order to simplify program administration and expedite distribution of funds to the Counties. Specifically, the DMH contends it streamlined the State/County performance contract (MHSA Agreement), changed many of the case management policies, and provided guidance on the use of unexpended funds from prior years.

The DMH informs Subcommittee staff that it included provisions in the MHSA Agreement with Counties to allow the addition of funding to the MHSA Agreement upon approval of a Plan update. This should expedite the distribution of funding by allowing Counties to rely on Board of Supervisors (Board) approval of MHSA Plans and by not requiring Board approval of each successive agreement modification.

The DMH also states it is moving to a cash-based system which ensures that sufficient MHSA Funds are available to support the total funding level by component for the subsequent fiscal year. According to the DMH this means that revenues will accumulate for 12 months in the State Mental Health Services Fund prior to distribution in the subsequent state fiscal year but will allow substantial cash payments to each County at the beginning of each fiscal year. Under this new policy, the DMH states that each County will receive 75 percent of the approved annual Plan amount upon Plan approval (and execution of a MHSA Agreement) or at the start of the fiscal year, whichever is later. The remaining 25 percent will be distributed upon submission of required reports, which include the semi-annual Local MHS Fund Cash Flow Statement and the Annual MHSA Revenue and Expenditure Report.

Further, the DMH states that it clarified that MHSA Funds should be expended and accounted for on a “first-in”, “first-out” basis (i.e., the first dollar distributed to the County is the first dollar spent on services irrespective of the fiscal year). Each County is to identify unspent funds and the use of such unspent funds through the annual Plan update process. Unexpended funds will be considered available to fund services in subsequent years and a County may dedicate unspent funds to a local prudent reserve.

The table below reflects the Administration’s proposed expenditures for the MHSA Funds as of January 2008. It should be noted that this table will be updated at the May Revision to reflect increased expenditures approved by the Mental Health Services Act Oversight and Accountability Commission (OAC) and the DMH.

Table: Administration’s Proposed *Expenditures* by Component *(January)*

Six Components of Mental Health Services Act (MHSA)	**2006-07 (Actual)**	**2007-08 (Estimated)**	**2008-09 (Projected as of January)**
Local Planning	--	--	--
Community Services & Supports	$352.1 million	$975.5 million	$921.4 million
Workforce Education & Training	--	$127.7 million	$172.3 million
Capital Facilities & Technology	--	$300 million	$148.9 million
Prevention and Early Intervention	--	$90.2 million	$250.8 million
TOTAL for Local Assistance	**$352.1 million**	**$1.493 billion**	**$1.493 billion**
TOTAL for State Implementation (Including all Departments)	$18.5 million	$39.5 million	$38.9 million **(increasing)**
TOTAL Overall	**$370.5 million**	**$1.532 billion**	**$1.532 billion**

The following descriptions outline the various local assistance components to the Act.

- Local Planning (County plans): Each county must engage in a local process involving clients, families, caregivers, and partner agencies to identify community issues related to mental illness and resulting from lack of community services and supports. Each county is to submit for state review and approval a three-year plan for the delivery of mental health services within their jurisdiction. Counties are also required to provide annual updates and expenditure plans for the provision of mental health services.
- Community Services and Supports. These are the programs, services, and strategies that are being identified by each county through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating racial disparity.

- Education & Training. This component will be used for workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.
- Capital Facilities and Technology. This component is intended to support implementation of the Community Services and Supports programs at the local level. Funds can be used for capital outlay and to improve or replace existing information technology systems and related infrastructure needs.
- Prevention & Early Intervention. These funds are to be used to support the design of programs to prevent mental illness from becoming severe and disabling.

Background—Mental Health Services Oversight & Accountability Commission (OAC). The Mental Health Services Oversight and Accountability Commission (OAC) is established to implement the Act and has the role of reviewing and approving certain county expenditures authorized by the measure. Members of the OAC are appointed by the Governor, Speaker of the Assembly, and the Senate Rules Committee.

Through the Executive Director of the OAC (Ms Jennifer Clancy), the OAC adopted a two-year work plan that provides a road map to effectively implement the OAC's statutory responsibilities. **Key responsibilities of the OAC include the following:**

- Provide the vision, leadership, and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, care, and support to California's living with mental illness.
- Ensure public *transparency* in all aspects of the Mental Health Services Act (Act) implementation, including planning, implementing, evaluating, and program and quality improvement.
- Advise the Governor and Legislature regarding actions the state may take to improve care and services for individuals experiencing mental illness.
- Provide oversight over the Act and ensure accountability to the intent and purpose of the Act through: **(1)** review and comment on *all* county plans for following the components of the Act; *and* **(2)** review and approve *all* county program expenditures using Mental Health Services Funds.
- Oversee the implementation of the Act's (1) Part 3—Community Services and Supports; (2) Part 3.1—Education and Training; (3) Part 3.2—Innovative Programs; and (4) Part 3.6—Prevention and Early Intervention.
- Identify critical issues related to the performance of County Mental Health programs and refer the issues to the Department of Mental Health
- Ensure funding from the Act leads to the intended outcomes of the Act.
- Develop and promote a statewide policy agenda that promotes a public mental health system prepared to reduce the long-term adverse impact on individuals, families, and state and local budgets resulting from untreated mental illness.

Subcommittee Staff Comment and Recommendation. *First*, it is recommended to above the Finance Letter as proposed, excluding the Housing component which will be discussed in a forthcoming Subcommittee #3 hearing.

Second, in an effort to clarify the DMH's use of contracting for certain functions, Subcommittee staff has worked with the DMH, the County Mental Health Directors Association and others to craft the following amendment (shown in underscore) to Section 4061 of Welfare and Institutions Code as follows:

> 4061 (a) The department shall utilize a joint state-county decision-making process to determine the appropriate use of state and local training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system. The department shall use the decision-making collaborative process required by this section in all of the following areas:
>
> (1) Provide technical assistance to the State Department of Mental Health and local mental health departments through direction of existing state and local mental health staff and other resources.
> (2) Analyze mental health programs, policies, and procedures.
> (3) Provide forums on specific topics as they relate to the following:
> (A) Identifying current level of services.
> (B) Evaluating existing needs and gaps in current services.
> (C) Developing strategies for achieving statewide goals and objectives in the provision of services for the specific area.
> (D) Developing plans to accomplish the identified goals and objectives.
> (4) Providing forums on policy development and direction with respect to mental health program operations and clinical issues.
> <u>(5) Identify and fund a statewide training and technical assistance entity jointly governed by local mental health directors and mental health constituency representation, which can:</u>
> <u>(A) Coordinate state and local resources to support training and technical assistance to promote quality mental health programs;</u>
> <u>(B) Coordinate training and technical assistance to assure efficient and effective program development; and</u>
> <u>(C) Provide essential training and technical assistance as determined by the state-county decision-making process.</u>

Legislative Analyst's Office. The LAO has raised no issues regarding this Finance Letter.

Questions. The Subcommittee has requested the DMH to respond to the following questions.

1. DMH, Please describe the changes the DMH has made regarding clarification of its fiscal policies in its administration of the Mental Health Services Act Funding.

2. DMH, Are MHSA Funds being distributed more efficiently to the Counties for local expenditure due to the fiscal changes? Please be specific.

3. DMH, Please provide a brief summary of the key components to the proposed Finance Letter, and comment regarding the proposed trailer bill language as noted above.